OMS-

INSURANCE VERIFICATION FORM

DEMOGRAPHICS

Patient Name :		DOB:	
Policy ID:		Group ID:	N/A
SS# :	2		

PRIMARY INSURANCE

Primary Insurance:	UHC	Phone#:	877-842-3210	Payor ID	87726
Effective Date:	01/01/2018	Claims Mailing Address:	PO BOX 31362 SALT LAKE CITY, UT 84131		
Name of Policy Holder:		Relationship to Patient:	SELF		
Policy Holder DOB:		Employer:			
Policy Type :	PPO-UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PPO)	Is this a MCR Replacement?	Y		
Ind Deductible:	$150.00	Ind Deductible Amount Met:	$150.00		
Fam Deductible:	$150.00	Fam Deductible Met:	$150.00		
Is it an annual deductible? Y/N	Y	Does deductible apply to office visit? Y/N	Y		
Out of Pocket Amount Max:	$1,200.00	Out of Pocket Amount Met:	$161.08		
Is an Optometrist considered a specialist?	Y	Office visit co-pay $	NO COPAY		
Is a PCP referral required? Y/N	N				
If yes, PCP Name and Phone #:	N/A	Referral #:	N/A		
Does this plan cover payment to an Optometrist for services? Y/N		Y			
NETWORK	UHC	PAR Y/N	Y		

CPT CODES / SUPPLIES

CPT Code	Covered Benefit	Applies Toward Ded	Auth Required	Auth Number
92004/92014 & 92002/92012 (Eye Exam Codes)	Y	N	N	N/A
99201-99205 & 99211-99215 (E&M Codes)	Y	Y	N	N/A
92081-92083 (Visual Field)	Y	Y	N	N/A
92250 (Fundus)	Y	Y	N	N/A
92132, 92133, and 92134 (Scanning Laser)	Y	Y	N	N/A
92025 (Corneal Topography)	Y	Y	N	N/A
68761 (Punctal Plugs)	Y	N	N	N/A
A4263 / A4262 (Punctal Plug Supplies)	Y	Y	BASED ON DX	N/A
92071 - Fitting of Contact Lens to Treat Ocular Surface Disease	N	N/A	N/A	N/A
92072 - Initial Fitting of Contact Lens to Treat Keratoconus	N	N/A	N/A	N/A
92310 (Contact Lens Fitting Fee)	N	N/A	N/A	N/A
95930 (Visual Evoked Potential)	Y	Y	N	N/A
83861(Tear Osmularity test)	Y	Y	N	N/A
65778(Prokera Amniotic lens)	Y	N	N	N/A
83516 (InflammaDry test)	Y	Y	BASED ON DX	N/A
V2531 (Contact lens, scleral, gas permeable, per lens supply)	N	N/A	N/A	N/A
76514	Y	Y	N	N/A
Is the refraction covered under the medical insurance plan? Y/N	Y			

ROUTINE / WELLNESS COVERAGE

Routine Vision Exam Benefit: Y/N	Y	Copay:	NO COPAY, COVERED @ 100% OF THE ALLOWED AMOUNT
Frequency of Benefit:	1 EXAM EVERY 12 MONTHS	Benefit Last Used:	NOT USED

Are the following materials covered?		If covered, what is the dollar amount?
Glasses: Y/N	N	NOT COVERED UNDER MED POL, NO VENDOR LISTED FOR DISCOUNT/BENEFITS.
Contact Lenses: Y/N	N	NOT COVERED UNDER MED POL, NO VENDOR LISTED FOR DISCOUNT/BENEFITS.

VISION PLAN INFO

Is our office is an in-network provider under the vision plan?	NOT PROVIDED
Name of Vision Plan: NO VENDOR LISTED	**Phone Number:** N/A
Claims mailing address for vision exam and materials.	NOT PROVIDED

NOTES

S/W BRENDA G. WITH UHC @ 877-842-3210, SHE STATED THAT PROVIDER IS IN-NETWORK WITH THE MEMBERS PLAN, EFF- 01/01/2018, PER REP-OV, X-RAY, LABS AND SURGERY IN OFFICE ARE COVERED 96% AFTER DED ($150.00 / MET-$150.00) AND 100% AFTER ($1,200.00 / MET-$161.08) IS MET. RVE IS COVERED @ 100% OF THE ALLOWED AMOUNT, LIMITED TO 1 EXAM EVRY 12 MONTHS AND PATIENT IS ELIGIBLE. REFRACTION IS COVERED WITH THE EXAM. CONTACT LENS FITTING FEE AND MAT'S ARE NOT COVERED UNDER MED POL, NO VENDOR LISTED FOR DISCOUNT/BENEFITS.CPT CODES 92071, 92071, 92310 AND V2531 ARE NOT COVERED, ALL OTHER CPT CODES ARE VALID AND BILLABLE BASED ON DX AND MEDICAL NECESSITY. FOR ALL CPT CODES THEY WILL FOLLOW ALL MCR GUIDELINES. VERIFICATION OF INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT.

Name of Insurance Rep:	BRENDA G.	**Date Called:**	06/15/2018	**Ref #:**	4

SECONDARY INSURANCE

Secondary Insurance:		**Phone#:**	**Payor ID**
Is this a Medicare Supplement Policy? Y/N			
Effective Date:		**Claims Mailing Address:**	
Name of Policy Holder:		**Relationship to Patient:**	
Policy Holder DOB:		**Employer:**	
Policy Type :		**Ind Deductible:**	
Ind Deductible Amount Met:		**Fam Deductible:**	
Fam Deductible Met:		**Is it an annual deductible? Y/N**	
Out of Pocket Amount Max:		**Out of Pocket Amount Met:**	
Name of Insurance Rep:		**Date Called:**	**Ref #:**

NOTES

Please be aware that verification of insurance benefits is not a guarantee of payment.